

# Welcome

## ABOUT YOU

Today's Date: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Name:** \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  Male  Female  
Last First Mi Mr Mrs Ms Dr

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  Single  Married  Divorced  Widowed  Separated

**Home Address:** \_\_\_\_\_  
Street City State Zip

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Mobile #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Driver License #: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_ Whom may we Thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

**Employer:** \_\_\_\_\_ How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

### Person to Contact in Case of Emergency

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

### Person Responsible for Account if other than yourself

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
Street City State Zip

## SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

### Primary Insurance

Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

### Secondary Insurance

Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

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## MEDICAL HISTORY

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**Your current physical health is:**  Good  Fair  Poor

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Have you ever taken Fosamax, or any other bisphosphonate?  Yes  No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath?  Yes  No

Do you smoke or use tobacco in any other form?  Yes  No

Have you ever had Dermal Fillers?  Yes  No

Have you ever had Botox?  Yes  No

**Are you allergic to any of the following?**

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions: \_\_\_\_\_

**For Women:** Are you taking birth control pills?  Yes  No

Are you pregnant?  Unsure  Yes  No

Week #: \_\_\_\_\_ Are you nursing?  Yes  No

**Are you taking any of the following?**

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes Drugs	Y N Thyroid Medicine
Y N Antibiotics	Y N Blood Pressure Medication	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs	Have you ever taken Phen-Fen? Also known as Redux or Pondimin. <input type="checkbox"/> Yes <input type="checkbox"/> No
Y N Aspirin	Y N Digitalis/Heart Medication	Y N Steroids/Cortisone	

Are you taking any prescription/over-the-counter-drugs/herbal supplements not listed above?  Yes  No If yes, please list each one: \_\_\_\_\_

**Do you or have you experienced the following?**

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Kidney Problems	Y N Seizures
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Liver Disease	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Lupus	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Psychiatric Problems	Y N Tonsillitis
Y N Cancer	Y N Fever Blisters	Y N HIV <sup>+</sup> /AIDS	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for Any Reason	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox	Y N Hay Fever		Y N Scarlet Fever	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: \_\_\_\_\_

## DENTAL HISTORY

**Why have you come to the dentist today?** \_\_\_\_\_

Are you currently in pain?  Yes  No

Do you require antibiotics before dental treatment?  Yes  No

Have you experienced problems associated with any previous dental work?  Yes  No

Have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?  Yes  No

Your current dental health is:  Good  Fair  Poor

Do you floss daily?  Yes  No Brush daily?  Yes  No

Type of bristles on your toothbrush?  Hard  Medium  Soft

How long do you use a toothbrush before replacing it? \_\_\_\_\_

Do you use anything in addition to your brush and floss?  Yes  No  
 If yes, what? \_\_\_\_\_

Would you like fresher breath?  Yes  No Whiter teeth?  Yes  No

Do your gums ever bleed?  Yes  No Ever Itch?  Yes  No

Have you ever had periodontal disease?  Yes  No

Do you have mobility in your teeth?  Yes  No

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

Have you ever lost any teeth?  Yes  No

If yes, would you like to have them replaced?  Yes  No

Previous / Present Dentist: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_  
(Please Circle)

Why did you leave your previous dentist? \_\_\_\_\_

**Are you happy with the way your smile looks?**  Yes  No

If not, what would you change? \_\_\_\_\_

**Is there anything that would stand in your way of getting the proper dental work you need?** \_\_\_\_\_

### AUTHORIZATIONS

Please read and sign to the right.

**PAYMENT IS DUE AT TIME OF SERVICE**

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need with my informed consent.

Signature \_\_\_\_\_

Date \_\_\_\_\_